

04077

4101 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL - Bel Air</u>		LENGTH OF STAY (in this place) <u>9 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL - Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>near Hickory</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOHN HENRY ANDERSON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 18 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>September 25, 1887</u>		<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Riley Anderson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Landis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Elmer R. Anderson (son), Aberdeen, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>Cerebro-vascular accident</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 weeks</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerosis</u>						<u>indefinite</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Recent prostatectomy for benign hypertrophy</u>						<u>5 weeks</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from April 12, 1956, to April 18, 1956, that I last saw the deceased alive on April 18, 1956, and that death occurred at 11:45 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Paul S. Stomwies Jr.</u>				<b>DATE SIGNED</b> <u>Apr. 19, 1956</u>			
<b>ADDRESS</b> (Street, city, town, state) <u>M.D. 115 Fulford Ave., Bel Air, Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>April 21/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Rock Spring Baptist</u>		<b>LOCATION</b> (City, town, or county) (State) <u>LANCASTER CO PENN.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>4-20-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Rebecca Lowndes</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J. Felt</u>		<b>ADDRESS</b> <u>Bel Air Md</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. BROWN  
 SEX: MALE AGE: 45  
 DATE OF BIRTH: 1910  
 PLACE OF BIRTH: NEW YORK  
 OCCUPATION: LABORER  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: HOME  
 DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 SIGNATURE OF PHYSICIAN: [Signature]  
 SIGNATURE OF REGISTRAR: [Signature]

DATE OF INTERVIEW: APRIL 15, 1956  
 TIME OF INTERVIEW: 10:30 AM  
 PLACE OF INTERVIEW: HOME  
 NAME OF INTERVIEWER: [Signature]  
 SIGNATURE OF DECEASED: [Signature]  
 SIGNATURE OF WITNESS: [Signature]

DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 PLACE OF DEATH: HOME  
 NAME OF DECEASED: JOHN J. BROWN  
 SEX: MALE AGE: 45  
 DATE OF BIRTH: 1910  
 PLACE OF BIRTH: NEW YORK  
 OCCUPATION: LABORER  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: HOME  
 DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 SIGNATURE OF PHYSICIAN: [Signature]  
 SIGNATURE OF REGISTRAR: [Signature]

DATE OF INTERVIEW: APRIL 15, 1956  
 TIME OF INTERVIEW: 10:30 AM  
 PLACE OF INTERVIEW: HOME  
 NAME OF INTERVIEWER: [Signature]  
 SIGNATURE OF DECEASED: [Signature]  
 SIGNATURE OF WITNESS: [Signature]

DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 PLACE OF DEATH: HOME  
 NAME OF DECEASED: JOHN J. BROWN  
 SEX: MALE AGE: 45  
 DATE OF BIRTH: 1910  
 PLACE OF BIRTH: NEW YORK  
 OCCUPATION: LABORER  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: HOME  
 DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 SIGNATURE OF PHYSICIAN: [Signature]  
 SIGNATURE OF REGISTRAR: [Signature]

DATE OF INTERVIEW: APRIL 15, 1956  
 TIME OF INTERVIEW: 10:30 AM  
 PLACE OF INTERVIEW: HOME  
 NAME OF INTERVIEWER: [Signature]  
 SIGNATURE OF DECEASED: [Signature]  
 SIGNATURE OF WITNESS: [Signature]

DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 PLACE OF DEATH: HOME  
 NAME OF DECEASED: JOHN J. BROWN  
 SEX: MALE AGE: 45  
 DATE OF BIRTH: 1910  
 PLACE OF BIRTH: NEW YORK  
 OCCUPATION: LABORER  
 CAUSE OF DEATH: HEART DISEASE  
 PLACE OF DEATH: HOME  
 DATE OF DEATH: APRIL 15, 1956  
 TIME OF DEATH: 10:30 AM  
 SIGNATURE OF PHYSICIAN: [Signature]  
 SIGNATURE OF REGISTRAR: [Signature]

**RECEIVED**  
 APR 23 1956  
 BUREAU V. S.

## 4102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> 182		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hess, Monkton</u>			c. LENGTH OF STAY IN 1b <u>4 mo</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hess, - Monkton, R.R.</u>			d. STREET ADDRESS <u>Hess, - Monkton, R.R.</u>		
3. NAME OF DECEASED (Type or print) <u>Carrie Wilson Ansell</u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1956</u> 19		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1869</u>	9. AGE (in years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Louise Ketten</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT <u>Mrs Bernard McKennie, Monkton</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Harford</u>	(County) <u>Harford</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Lerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/1/56</u>	
EXAMINER'S NAME (Type) <u>Gerold C. Palmer M.D.</u>		DISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 4/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Rural</u>	22d. LOCATION (City, town, or county) <u>Chester</u>	(State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Hutz</u>		ADDRESS <u>Janetville Rd</u>		24a. REC'D BY REGISTRAR DATE <u>4/3/56</u>	24b. REGISTRAR'S SIGNATURE <u>Priscilla Lownd</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Health Department. Give Page 5 to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

0007

1935

APR

CHIEF OF BUREAU

CLERK

DEPT. OF HEALTH

NEW YORK

RECEIVED

JAMES H. HARRIS

DEPT. OF HEALTH

NEW YORK

BUREAU V. 2

APR 5 1935

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04079

Item 7, Film 197 5-14-56 et

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	
f. STREET ADDRESS <u>RD</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Spencer Bishop</u>		4. DATE OF DEATH <u>April 20 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1938</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUSSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Jerome Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Sara A. Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-7835</u>	
17. INFORMANT <u>OSCAR J. Bishop</u>		Address <u>HAYRE DE GRACE, P.D. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound, comminuted</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound Fracture Left arm + Right arm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>April 20 1956</u> Hour <u>12 30</u> o. m. <u>PM</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD Hart-de Grace</u>		20f. City or town <u>Hartford</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APR 23 1956</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Gravel Hill</u>		22d. LOCATION (City, town, & county) <u>Hartford</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u>		ADDRESS <u>Hartford, MD</u>	
24a. REC'D BY REGISTRAR <u>APR 23 1956</u>		DATE <u>APR 23 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>			

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 26 1956  
BUREAU V. 8

4104

## CERTIFICATE OF DEATH

04080

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural. 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Level Area.</u>		d. STREET ADDRESS <u>Level Area.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Webster</u> Last <u>Bowman.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23rd</u> Year <u>1956</u>	
5. SEX <u>Male.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 - 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James P. Bowman</u>		14. MOTHER'S M maiden name <u>Jennie Gorrell.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Minna J. Taylor</u>		Address <u>Aberdeen 2. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/22</u> , 19 <u>56</u> , to <u>4/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>56</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.P. Smogness</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington Md.</u>	
PHYSICIAN'S NAME (Type) <u>E.P. Smogness</u>		DATE SIGNED <u>4/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Haver de Grace R.T. Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barving</u>		ADDRESS <u>Aberdeen Maryland.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Willie G. Perry</u>	

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

BUREAU V. S.

APR 27 1956

RECEIVED

**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4105

# CERTIFICATE OF DEATH

04081

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b> COUNTY <u>Hartford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>MD</u> COUNTY <u>Hartford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> TOWN STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (First) <u>Charles</u> (Middle) <u>Hilditch</u> (Last) <u>Barkins</u> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married Dec 13 1898</u>	<b>8. DATE OF BIRTH</b> <u>5/7</u> yrs.
<b>9. AGE last birthday</b> <u>57</u> yrs.		<b>10. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-employed</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hartford Co MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Wm Barkins</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Hilditch</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>220-24-1456</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Sarah Knopp Barkins Forest Hill MD</u>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> 154A IMMEDIATE CAUSE (A) <u>Carcinoma rectum with wide</u> ANTECEDENT CAUSE(S) DUE TO <u>metastases</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>metastases</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>24 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b> <u>Feb 15 1956</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Carcinoma + metastases</u>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>21. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>	
<b>21f. HOW DID INJURY OCCUR?</b>		<b>22. I hereby certify that I attended the deceased from</b> <u>1/15</u> <u>1956</u> , to <u>4/30</u> <u>1956</u> , that I last saw the deceased alive on <u>4/11</u> <u>1956</u> , and that death occurred at <u>5A</u> <u>M.</u> from the causes and on the date stated above.	
<b>SIGNATURE</b> <u>Lorald e Palmer</u>		<b>DATE SIGNED</b> <u>4/30/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>24. REC'D BY REGISTRAR</b> <u>May 2/56</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph J. Lister</u>		<b>26. ADDRESS</b> <u>Belt Air Md</u>	

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Lowell - Palmer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4087

CERTIFICATE OF DEATH

Reg. Dist. No.

04882  
1885

1. PLACE OF DEATH o COUNTY <u>Harford</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>				c. LENGTH OF STAY IN 1b <u>9 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Woodlawn Trailer Park</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Campbell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1956</u>	9. AGE (In years last birthday) yrs. <u>9</u> Min <u>11</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Franklin Eugene Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harb. Records Harford Grace Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY. (Wgt 4 LBS 15oz)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45</u> A. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>R.B. Norment M.D.</u>				<u>Harford Grace</u> <u>4-4-56</u>			
PHYSICIAN'S NAME (Type) <u>R.B. NORMENT</u>				<u>HAVRE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/5/56</u>		<u>Md. Eun</u>		<u>Harford Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Peru, Harford Grace, Md.</u>				<u>DATE 4-4-56</u>		<u>A.L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04083

Reg. Dist. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>151 W. Deen Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert A. Carlton</u>		4. DATE OF DEATH <u>April 25 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Oct. 1914</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Carlton</u>		14. MOTHER'S MAIDEN NAME <u>Marita Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Current</u>		16. SOCIAL SECURITY NO. <u>621-18-8572</u>	
17. INFORMANT <u>Renée Carlton</u>		Address <u>151 W. Deen ave, Aber.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OVER</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by train</u>	
20c. TIME OF INJURY Month, Day, Year <u>Apr. 1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pennington Rd.</u>	
20f. (City or town) <u>Aberdeen</u>		(County) <u>Harford</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>30 Apr. 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarrington</u>		ADDRESS <u>Arlington National</u>	
24a. REC'D BY REGISTRAR <u>Apr 30 56</u>		24b. REGISTRAR'S SIGNATURE <u>Mellie R Perry</u>	

DATE SIGNED 4/26/56

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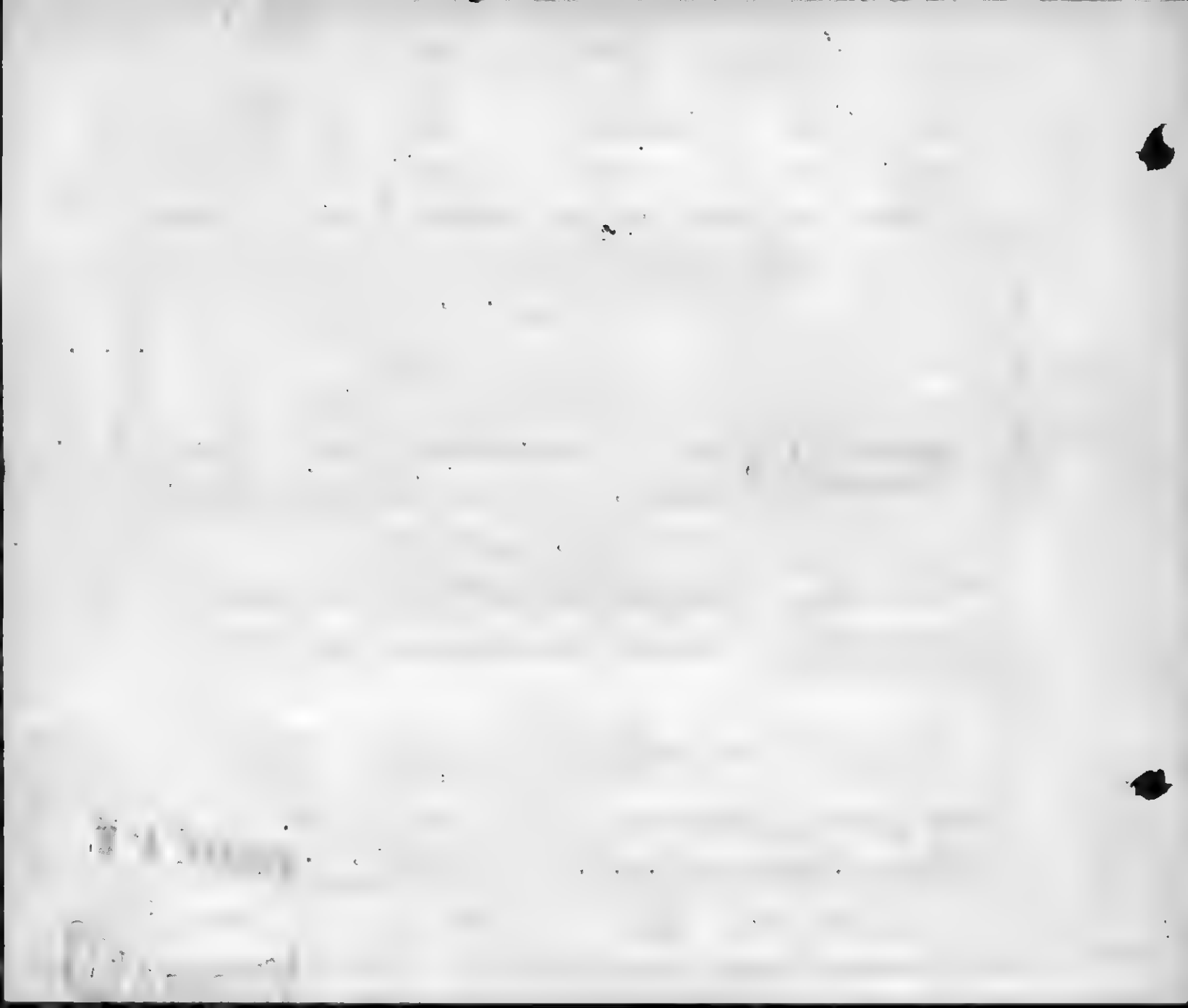
CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
				d. STREET ADDRESS <b>Webster Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>MONNETT</b> Last <b>CASS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1874</b>	
				9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Ohio</b>			
13. FATHER'S NAME <b>Abram Monnett</b>				14. MOTHER'S MAIDEN NAME <b>Jane Walwork</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <b>Mrs. Elizabeth Wills (daughter), Bel Air, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, terminal</b>				<b>2 weeks</b>			
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				(b) <b>Carcinomatosis, general</b>			
				DUE TO			
				(c) <b>Adenocarcinoma of rectum, grade I</b>			
				<b>8 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 2</b> , 19 <b>56</b> , to <b>April 20</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 19</b> , 19 <b>56</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>115 Fulford Ave., Bel Air, Md.</b>							
DATE SIGNED <b>4/20/56</b>							
ACTUAL SIGNATURE <b>Paul S. Stonesifer, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Paul S. Stonesifer, Jr. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Apr 23, 1956</b>		<b>Oakwood Cemetery</b>		<b>Bucyrus Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Archer</b>				ADDRESS <b>Benson - Md</b>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <b>Russella Lowmood</b>			
DATE <b>4-28-56</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04085

## 4106 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>	LENGTH OF STAY (in this place) <u>2 yr</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>	TOWN <u>Burlington</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Emma</u> (Middle) <u>May</u> (Last) <u>Chandler</u>		(Month) <u>April</u> (Day) <u>30</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 31 1882</u>
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11. BIRTHPLACE (State or foreign country) <u>Harford Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gen. Henry White</u>		14. MOTHER'S MAIDEN NAME <u>Susan E. Gates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>111</u>	
17. INFORMANT'S ADDRESS <u>Mr. Henry White</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>		<u>1 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>		<u>4 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 30, 1956</u> , to <u>May 30, 1956</u> , that I last saw the deceased alive on <u>May 30, 1956</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Neddy Phillips M.D.</u>		DATE SIGNED <u>5/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Burlington</u>	
DATE THEREOF <u>May 3, 1956</u>		LOCATION (City, town, or county) <u>Burlington</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>C. K. K. K.</u>		ADDRESS <u>Burlington</u>	
DATE <u>May 4, 1956</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05171
Item 21: film G198 6-7-56										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b> c. LENGTH OF STAY IN 1b <b>-</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital DOA</b>					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster</b> d. STREET ADDRESS <b>1103 New Holland av.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>EUGENE</b> Last <b>CHECKLEY</b>					4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1914</b>		9. AGE (In years last birthday) <b>41</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner and Manager</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>HARRY CHECKLEY</b>					14. MOTHER'S MAIDEN NAME <b>HELEN KLOSE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>196 10 9887</b>		17. INFORMANT <b>Mrs. Paul Checkley</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) <b>GERALD C. PALMER</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<b>4/26/56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4</b>		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan Funeral Home, Lancaster Pa.</b> ADDRESS					24a. REC'D BY REGISTRAR <b>6/8/56</b> DATE		24b. REGISTRAR'S SIGNATURE <b>a. H. Hedrick</b>			

BUREAU V. S.

JUN 10 1900

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04086

4108

## CERTIFICATE OF DEATH

Reg. Dist. No. 1 P. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>EMMORTON</u>		<u>2 years</u>		TOWN <u>EMMORTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FANNIE</u> (Middle) <u>COCHRAN</u> (Last) <u>X</u>				(Month) <u>April</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct 27 - 1920</u>	9. AGE last birthday <u>35</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>W M Cole</u>				14. MOTHER'S MAIDEN NAME <u>Solary Christian</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or rank.) <u>✓</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Clinton Cochran Bel Air Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma Cervix Uteri</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>with wide metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6/1/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma cervix</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/15</u> ....., 19 <u>55</u> ., to <u>4/9</u> ....., 19 <u>56</u> ., that I last saw the deceased alive on <u>4/9</u> ....., 19 <u>56</u> ., and that death occurred at <u>5P</u> ....., M., from the causes and on the date stated above.							
SIGNATURE <u>Lerald C Palmer</u> M.D.				ADDRESS (Street, city, town, state) <u>Bel Air Md.</u>		DATE SIGNED <u>4/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>April 12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wilmington Baptist</u>		LOCATION (City, town, or county) (State) <u>Hickory, Hartford Md.</u>	
24. REC'D BY REGISTRAR <u>4-12-56</u>		REGISTRAR'S SIGNATURE <u>Prueella Fourwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster Bel Air Md.</u>			

THE UNIVERSITY OF CHICAGO

1954

1954

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4109

## CERTIFICATE OF DEATH

04087

Reg. Dist. No.

181

1 PLACE OF DEATH a. COUNTY Harford MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Md				d STREET ADDRESS RED #2 Poplar Hill			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First James Middle Thomas Last Connelly				4 DATE OF DEATH Month April Day 14 Year 1956			
5. SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH April 14 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Mins.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA			
11. BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? USA			
13 FATHER'S NAME William Joseph Connelly Jr				14 MOTHER'S MAIDEN NAME Gertrude Mary Burgess			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO None		17. INFORMANT Father (as in 2)	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Maternal congenital anomalies of uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7 hr 48 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 14 Apr 1956, to 14 Apr 1956, that I last saw the deceased alive on 14 Apr 1956, and that death occurred at 1030 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE V. G. COSERIU Capt MC				M.D. US Army Hospital Aberdeen PG Md 14 Apr 56			
PHYSICIAN'S NAME (Type) V. G. COSERIU Capt MC							
22a BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/17/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b REGISTRAR'S SIGNATURE	
John G. Gorman		Aberdeen, Md.		DATE Apr 17 56		Thelma G. Henry	

2050212XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4110

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Creswell Road</u>		d. STREET ADDRESS <u>Creswell Road</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Charles Eisner</u>		4. DATE OF DEATH <u>April 7th 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Eisner</u>		14. MOTHER'S MAIDEN NAME <u>Christina Hess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert H. Eisner - 215 Park St. Aberdeen Md.</u>		Address <u>215 Park St. Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Arteriosclerosis C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>50</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>  </u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph Horky</u> M.D.		DATE SIGNED <u>April 7</u>	
PHYSICIAN'S NAME (Type) <u>Ralph Horky MD</u>		<u>Churchville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Babers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrung</u>		ADDRESS <u>Aberdeen Md.</u>	24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>Nellie G. Perry</u>

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 10 1956

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4111

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - BELAIR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - FOREST HILL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ENFIELD</b> Last <b>ENFIELD</b>				4. DATE OF DEATH Month <b>APR.</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUN 28, 1873</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER - RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRI.</b>		11. BIRTHPLACE (State or foreign country) <b>HARFORD CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WM. ENFIELD</b>				14. MOTHER'S MAIDEN NAME <b>TACY WEEKS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MRS. BESSIE S. ENFIELD, FOREST HILL, MD.</b>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Chr. cardio-vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>July</b> 19 <b>46</b> , to <b>April 11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>56</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Willard P. Hudson</b>	ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>4-11-56</b>
NAME (Type) <b>Willard P. Hudson, M.D.</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-14-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SLATEVILLE</b>	22d. LOCATION (City, town, or county) (State) <b>DELTA, PA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Haskins</b>		ADDRESS <b>Delta, Pa.</b>	24a. REC'D BY REGISTRAR <b>4-13-56</b>
		24b. REGISTRAR'S SIGNATURE <b>Phyllis Toward</b>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1900

RECEIVED

**INSTRUCTIONS**

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4112 CERTIFICATE OF DEATH

04090

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Harford Co.</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Forest Hill</u>	<u>Entire life</u> <u>47 yrs</u>	TOWN <u>Forest Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>ARIEL STANDIFORD</u>		<u>April 11</u> <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Apr 1<sup>st</sup> 1884</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
<u>72</u> yrs.	<u>Housewife</u>		<u>Ind.</u>
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME
<u>U.S.A.</u>	<u>Charles R. Standiford</u>		<u>Cassandra Knight</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
		<u>Frank O Foard</u> <u>Forest Hill Md</u>	
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>15.3X</u> IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>			<u>48 hours.</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>Coronary sclerosis</u>			<u>2</u>
(C) <u>Adeno-carcinoma of large intestine with generalized metastases.</u>			<u>2</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
<u>Diabetis Mellitus; Arthritis</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>March 14, 1956</u>	<u>Carcinoma of transverse colon; Generalized metastases.</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>52</u> , to <u>April 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>William P. Hudson M.D.</u>		<u>April 12, 1956</u>	
ADDRESS (Street, city, town, state)		LOCATION (City, town, or county) (State)	
<u>Forest Hill</u>		<u>Forest Hill Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>	<u>Apr 13-56</u>	<u>Centre</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
<u>4-16-56</u>	<u>P. Wallace Howard</u>	<u>Martha E. Hunt</u>	<u>Janettsville Md</u>

RECEIVED

APR 20 1956

JOHN A. B. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4113

## CERTIFICATE OF DEATH

Reg. Dist. 0409B1

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#338 Parke Street.</i>		d. STREET ADDRESS <i>#338 A. Parke Street.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Stella</i> Middle <i>O.</i> Last <i>Gallione</i>		4. DATE OF DEATH Month <i>April</i> Day <i>13</i> Year <i>1956.</i>	
5. SEX <i>Female.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 8th 1873</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>William Greenland.</i>		14. MOTHER'S MARRIED NAME <i>Annie Pullum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>None.</i>	
17. INFORMANT <i>Lester G. Gallione</i>		Address <i>Aberdeen Maryland.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO <i>Cerebral Anemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Heart Block</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>2 wk</i> <i>2 wk</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-22-</i> , 19 <i>55</i> to <i>4-13-</i> , 19 <i>56</i> , that I lost saw the deceased alive on <i>4-12-56</i> , 19 <i>56</i> , and that death occurred at <i>6:10 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Peter P. Rodman</i> M.D. <i>Peter P. Rodman, M.D.</i> PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/15/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bakers cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen Maryland.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Farring</i> ADDRESS <i>Aberdeen Maryland.</i>		24a. REC'D BY REGISTRAR <i>Rev. 15-56</i>	24b. REGISTRAR'S SIGNATURE <i>William C. Terry</i>

BROWN V. S.

1871

1871

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

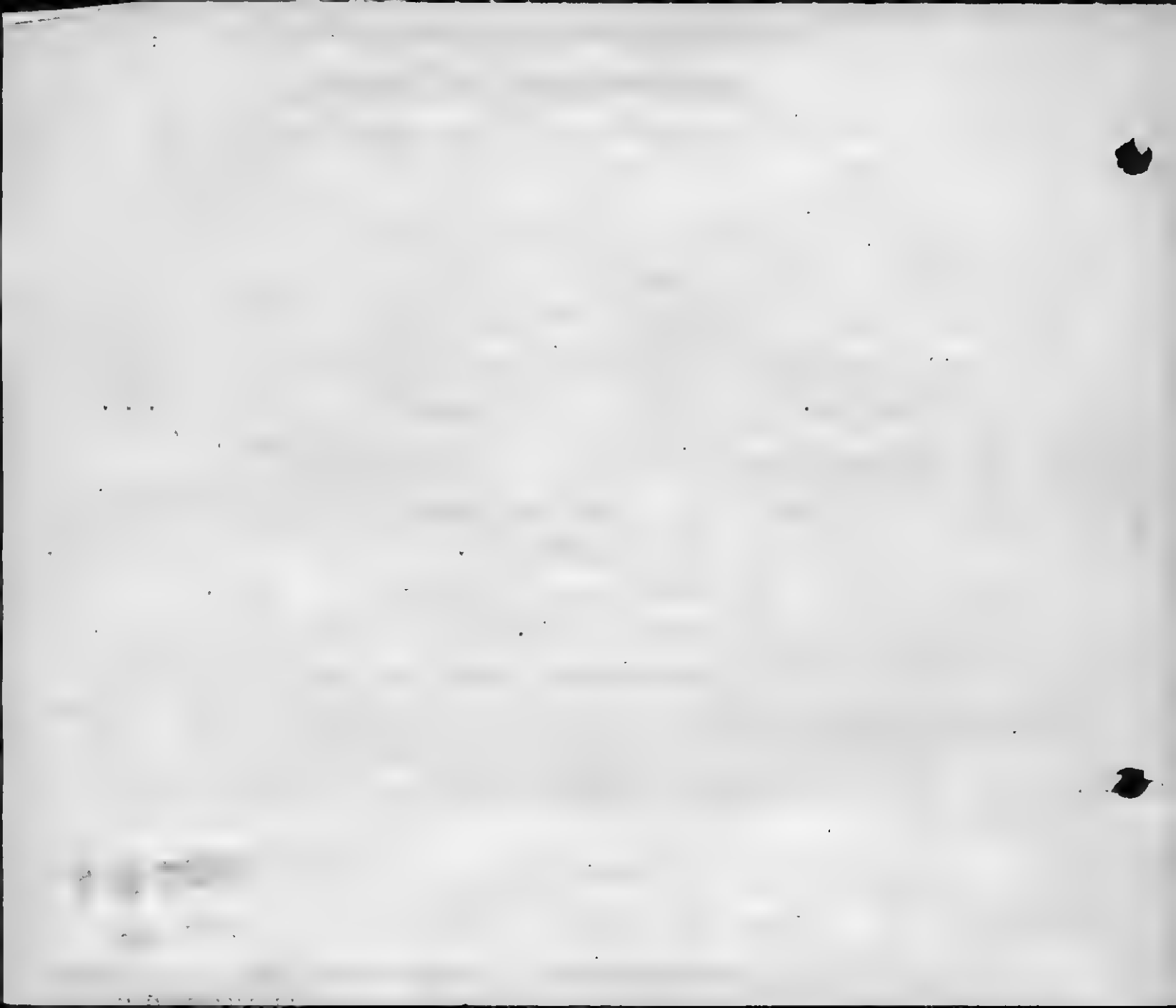
04092

4107

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>		LENGTH OF STAY (In this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>L</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Dora Phipps Goss</u>				<b>4. DATE OF DEATH</b> (Month) <u>April</u> (Day) <u>13</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6-1875</u>		9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>For. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Floyd Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Standiford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Floyd Goss Forest Hill Md RD</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic hypertensive cardio-vascular disease.</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis.</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>March 19</u> , 19 <u>56</u> , to <u>April 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William F. Hedgcock</u>				ADDRESS (Street, city, town, state) <u>Forest Hill</u>		DATE SIGNED <u>April 13, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist</u>		LOCATION (City, town, or county) (State) <u>Schuylers Corner Harford Md</u>	
24. REC'D BY REGISTRAR <u>4-14-56</u>		REGISTRAR'S SIGNATURE <u>Lucille Townsend</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. H. Bell</u>			



## 4091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>one day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air,</b>	
		d. STREET ADDRESS <b>129 Thomas Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Corene</b> Middle <b>Haughay</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1870</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>45 1/2 old County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Haughay</b>		14. MOTHER'S MAIDEN NAME <b>John Haughay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>111-111-1111</b>	
17. INFORMANT <b>Montford Haughay</b>		Address <b>111-111-1111</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture R. femur</b> <b>903.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>903.0</b> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Fell on floor of her room</b>	
20c. TIME OF INJURY Month, Day, Year <b>2 April 9 1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Bel Air Harford Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		DATE SIGNED <b>April 10, 1956</b>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>22/13/1956</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Harford Memorial Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Haughay</b>		24a. REC'D BY REGISTRAR <b>4/11/1956</b>	
ADDRESS <b>111-111-1111</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 111-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 20 1950

RECEIVED

4114

## CERTIFICATE OF DEATH

Reg. Dist. No. 1808

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor - Monkton Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Monkton Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Montgomery</u> Middle <u>Hill</u> Last		4. DATE OF DEATH <u>Apr</u> Month <u>20</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 1863</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Burwith W.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carlton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Edward J Mc Dermott</u>		Address <u>Monkton Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Hypertensive arteriosclerosis Ht. Dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4/12 - 4/18/56</u> <u>4/6 - 4 - 29/56</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>56</u> , to <u>April 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>56</u> , and that death occurred at <u>8:20 A</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Janettsville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>S. James Thomison, Jr.</u> M.D.		DATE SIGNED <u>4/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 23-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Hunt</u>		24a. REC'D BY REGISTRAR DATE <u>4-24-56</u>	
ADDRESS <u>Jane Lovelle</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Foxworth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 26 1956

BUREAU V. S.

4115

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL FAWN GROVE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL FAWN GROVE PA.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>N. OSCAR HUNSBERGER</b>				4. DATE OF DEATH Month Day Year <b>4-8-1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-19-1871</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>YORK CO., PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN HUNSBERGER</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN ROATS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Thos Walter Swift Fawn Grove Pa</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure due to chronic</b> <b>432.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocarditis, broncho-pneumonia &amp;</b> DUE TO (c) <b>general infirmities of old age.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Mon. 27, 1956, to Apr. 8, 1956</b> , that I last saw the deceased alive on <b>Apr. 8, 1956</b> , and that death occurred at <b>4:30 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman H. Gemmill</b>				ADDRESS (Street, city or town, state) <b>Stewartstown Pa</b>			
DATE SIGNED <b>4/9/56</b>							
PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAWN GROVE</b>		22d. LOCATION (City, town, or county) (State) <b>FAWN GROVE, YORK CO., PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Graham</b>				ADDRESS <b>Stewartstown Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>4-10-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie L. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIRAZ A. 2

AF3

1000 1000 1000

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the deceased. The law requires that the death certificate be executed within 24 hours after the death of the deceased.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04096

Reg. Dist. No.

185-

4092

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>Navre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <u>Harford Memorial Hospital</u>		d. STREET ADDRESS: <u>P.O. Box 78</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Bou</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1956</u>
9. AGE (In years last birthday) yrs <u>23</u> Months <u>23</u> Days <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Calvin Clay Jones</u>		14. MOTHER'S MAIDEN NAME <u>Luah Lee Lambill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pre-Viable Baby</u> DUE TO <u>Prenatal &amp; Retardation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>23 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>56</u> , to <u>4-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>56</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-21-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-22-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Navre de Grace MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Dally</u>		ADDRESS <u>Administrator</u>	
24a. REC'D BY REGISTRAR DATE <u>Apr 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>G. H. Lewis M.D.</u>	

CHAS. V. S.

APR 23 1900

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN ON HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04097

## 4116 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harford</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Marvin Knight</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4/12/56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/11/1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Everdeen Paving Ground</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Everdeen Paving</u>	9. AGE last birthday <u>57</u> yrs IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marvin Knight</u>		14. MOTHER'S MAIDEN NAME <u>Clara D. Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-1-64131</u>	
17. INFORMANT & ADDRESS <u>Marvin Knight</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1. IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 7, 1947</u> , to <u>April 9, 1956</u> , that I last saw the deceased alive on <u>April 7, 1956</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William Dudley Phillips</u> M.D.		ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u>	
DATE SIGNED <u>4/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/12/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Harford Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>John C. G. Knight</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Knight</u>	
REGISTRAR'S SIGNATURE <u>John C. G. Knight</u>		ADDRESS <u>Harford, Md.</u>	
DATE <u>April 9, 1956</u>			

RECEIVED  
JUN 10 1900  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04098

4093

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived). If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 Rut Royal Ave.</u>				d. STREET ADDRESS <u>65 Rut Royal Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>Conrad</u> Middle <u>Brouse</u> Last				4. DATE OF DEATH <u>April</u> Month <u>27</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21-1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Steam Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Conrad Brouse</u>				14. MOTHER'S MAIDEN NAME <u>Amie Grexer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-0127</u>		17. INFORMANT <u>Mrs Paul C. Brouse</u> Address <u>Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u>Coronary Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>5 yr.</u> <u>5 yr.</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>April 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>56</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u> DATE SIGNED <u>4-30-56</u>							
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Farney</u> ADDRESS <u>Aberdeen Md.</u>				24. REC'D BY REGISTRAR <u>April 30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Thelma K. Perry</u>	

RECEIVED

MAY 2 - 1956

BUREAU V. S.

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04099

## 4094 CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air,</u>		<u>5 Mo.</u>		TOWN <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Convalescent Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Ernest Lackey</u>				<u>April 30 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Widow</u>	<u>February 2, 1870</u>	<u>86</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Laborer</u>		<u>Black Smith</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Henry Lackey</u>				<u>Mary Jane Bunce</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
(If Yes, give war or dates of service)							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>Coronary Thrombosis (Acute)</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>230000</u> <u>141.</u> <u>7</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(B)</b> <u>Chronic Decompensated Cardio- Vascular Disease</u>							
<b>(C)</b> <u>Arterio-sclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>May 1, 1952</u>, to <u>April 30, 1956</u>, that I last saw the deceased alive on <u>April 29, 1956</u>, and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Wesley P. Hudson M.D.</u>				<b>ADDRESS (Street, city, town, state)</b> <u>Forest Hill, Md.</u>			
<b>DATE SIGNED</b> <u>April 30, 1956</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>BURIAL</u>		<u>May 5/56</u>		<u>Rock Spring Episcopal</u>		<u>Forest Hill Harford Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>4-30-56</u>		<u>Priscilla Lowwood</u>		<u>Joseph J. H. Belan</u>		<u>1001</u>	

RECEIVED

MAY 2 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4117

CERTIFICATE OF DEATH

Reg. Dist. No.

04100

18

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>				d. STREET ADDRESS <b>301 Market Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>Nellie</b> Last <b>Livingston</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1888</b>	
9. AGE (in years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None Home</b>		11. BIRTHPLACE (State or foreign country) <b>Grand Rapids, Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Adrian Baker</b>				14. MOTHER'S MAIDEN NAME <b>Jacoba Klaassen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-22-9573</b>		17. INFORMANT <b>Carl S Livingston</b> Address <b>1411 Hillcrest NW Grand Rapids, Michigan</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal varices with massive hemorrhage</b> <b>381.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver</b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b></b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>21 Apr</b> , 19 <b>56</b> , to <b>22 Apr</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>22 Apr</b> , 19 <b>56</b> , and that death occurred at <b>1157P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>R. S. Whitman</b>				M.D. <b>US Army Hospital Aberdeen PG Md</b> <b>23 Apr 56</b>			
PHYSICIAN'S NAME (Type) <b>R. S. WHITMAN, Capt MC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Farrier</b>				ADDRESS <b>Aberdeen Md.</b>		24a. REC'D BY REGISTRAR <b>25-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Nellie K Perry</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 26 1956

BUREAU OF

## 4095 CERTIFICATE OF DEATH

Reg. Dist. No. 186-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Harvz de Grace</i>		LENGTH OF STAY (in this place) <i>56 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harvz de Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hartford Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>354 Cowden St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>John Taylor Maurice</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>April-9, 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9/17/90</i>	9. AGE last birthday <i>65</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed Unknown</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Aberdeen, Maryland</i>	
13. FATHER'S NAME <i>Frank Maurice</i>				14. MOTHER'S MAIDEN NAME <i>Annie (Thalman)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS <i>Anna S. Maurice, Harvz de Grace, Md.</i>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422a. IMMEDIATE CAUSE (A) <i>Pericardial Effusion</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic Myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Coronary Atherosclerosis</i>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)				21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-8</i> 19 <i>56</i> to <i>April 9</i> 19 <i>56</i> , that I last saw the deceased alive on <i>4-9</i> 19 <i>56</i> , and that death occurred at <i>7:30</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>G. L. Lewis, M.D.</i>				ADDRESS (Street, city, town, state) <i>Harvz de Grace - April 11-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/12/56</i>		NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		LOCATION (City, town, or county) (State) <i>Harvz de Grace, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis, M.D.</i>		25. MINERAL DIRECTOR'S SIGNATURE <i>James H. ...</i>		ADDRESS <i>Harvz de Grace, Md.</i>	
DATE <i>Apr. 11-1956</i>							

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

100

*[Faint handwritten notes at the bottom of the page]*

— 20 —

*[Faint handwritten notes at the bottom of the page]*

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04102

## 4118 CERTIFICATE OF DEATH

Reg. Dist. No. 182.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL or give nearest town) TOWN <u>WHITEFORD RD#1</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL WHITEFORD RD#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLOTTE ELIZABETH MERRYMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4-18-1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11-18-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours M n.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>AMOS D. HARRISON</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>H Clayton Merryman Whiteford RD#1 Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH -				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Gangrene of left foot</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular-renal disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Leukemia thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 9, 1956</u> , to <u>April 18, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward R. Tyson</u>		M.D.		ADDRESS (Street, city, town, state) <u>Fawn Grove Pa</u>		DATE SIGNED <u>4/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4-21-56</u>	NAME OF CEMETERY OR CREMATORY <u>FAWN GROVE</u>		LOCATION (City, town, or county) <u>FAWN GROVE, YORK Co., Pa.</u>			
24. REC'D BY REGISTRAR <u>4-20-56</u>	REGISTRAR'S SIGNATURE <u>Priscilla Louwood</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W Graham</u>		ADDRESS <u>Stewartstown Pa.</u>			

APR 1 1950

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

041193

4119

## CERTIFICATE OF DEATH

Reg. Dist. No. 1.1

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Joppa - Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Joppa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Old Philadelphia Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Abraham</u> (First) <u>Millstein</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>60 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shoe maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Israel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Sarah Millstein - Same</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Coronary thrombosis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis(c) Coronary thrombosis August 1955

INTERVAL BETWEEN ONSET AND DEATH

5 min +1 yr +

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

asthma

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 11, 1955, to Apr. 22, 1956, that I last saw the deceasedalive on Feb. 17, 1956, and that death occurred at 6:35 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

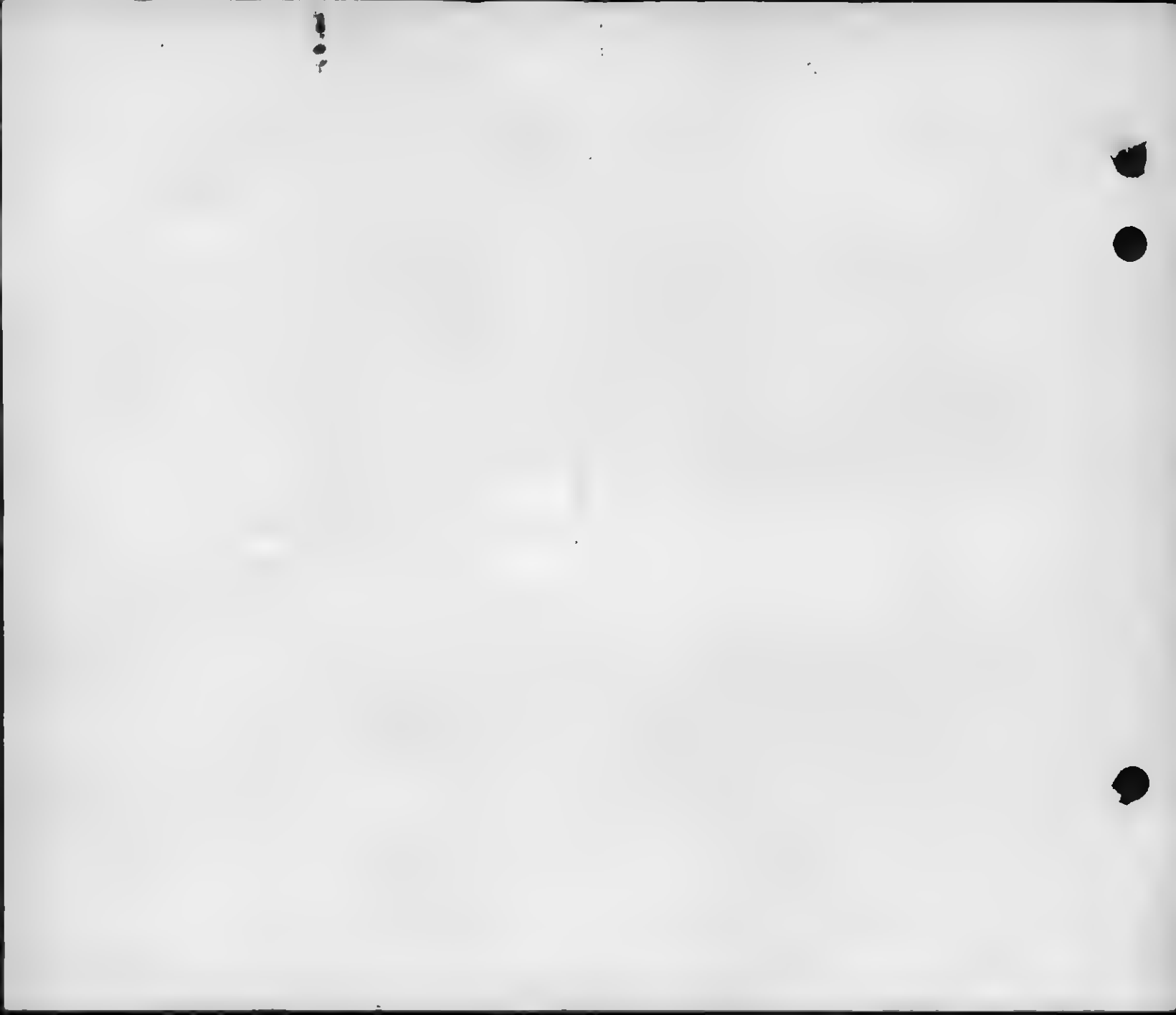
23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (city, town, or county) (State)
<u>Buried</u>	<u>4-25-56</u>	<u>Rosedale</u>	<u>Balto Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR'S ADDRESS	
		<u>Jack Lewis Ave 2100 Cutlers Pl</u>	

John call Dr. Palmer, Coroner. Bel Air as death sudden. I had not been called or consulted since Feb. 7, 1956.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Vollie</u> First <u>Abingdon</u> Middle Last <u>Minton</u> <b>5 SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 16, 1885</u> <b>9 AGE</b> (In years last birthday) <u>71</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <u>April 29</u> 19 <u>56</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>N.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Pervis Minton</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Minerva Ellers</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>241 40 8891</u> <b>17. INFORMANT</b> <u>Mrs Vollie Minton, Abingdon</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> <b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer M.D.</u>		<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u> <b>22b. DATE THEREOF</b> <u>Apr. 29, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Reins-Sturdivant, Inc.</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>North Wilkesboro, Wilkes Co., N.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComes &amp; Son</u>		<b>24a. REC'D BY REGISTRAR</b> <u>4/30, 1956</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Norma E. Moore</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate pending the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4096

CERTIFICATE OF DEATH

Reg. Dist. No. 186-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel de Grace</u>		c. LENGTH OF STAY IN <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>MAE</u> Last <u>CARLEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Mask Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Brady</u>		14. MOTHER'S MAIDEN NAME <u>MARY HORNBERGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7169</u>	
17. INFORMANT <u>Mrs. E. Collins</u>		Address <u>516 K.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio</u> <u>vascular Hypertension</u> (b) <u>Coronary Thrombosis</u> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 23 1956</u> , to <u>April 26 1956</u> , that I last saw the deceased alive on <u>April 26 1956</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>May 4/26/56</u>			
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 30, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs &amp; Son</u> ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>May 1-1956</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

U. S. A.

2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4097

## CERTIFICATE OF DEATH

04106

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>	
c. LENGTH OF STAY IN TB <b>1 1/2 DAYS</b>		d. STREET ADDRESS <b>721 Revolution</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willia</b> Middle <b>Pollitt</b> Last <b>Pollitt</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 29, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years, last birthday) yrs. <b>64</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Travers</b>		14. MOTHER'S MAIDEN NAME <b>MARY MARSHALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Sara West, 1231 Apple St. Wilm. Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4:30 PM</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Pulmonary Edema</b> (c) <b>Hypertensive Cardio-vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 days</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/14/56</b> , 19 <b>56</b> , to <b>4/17/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/17/56</b> , 19 <b>56</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Wadsworth M.D.</b>		ADDRESS (Street, city or town, state) <b>Harrel Grace, Md</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. Wadsworth</b>		DATE SIGNED <b>4/16/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/19/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gravelawn Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Farmhurst, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. H. Wadsworth</b>		24a. REC'D BY REGISTRAR <b>APR 17 1956 - G. F. Lewis M.D.</b>	

BURMAN V. S.

APR 20 1900

RECEIVED

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
c. LENGTH OF STAY IN 1b <i>6 days</i>		d. STREET ADDRESS <i>R.D. # 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George Orman Preston</i>		4. DATE OF DEATH Month Day Year <i>April 4 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 5th 1886</i>
9. AGE (In years last birthday) <i>69 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer and Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Alexander Preston</i>		14. MOTHER'S MAIDEN NAME <i>Alice Shay</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT Address <i>Mrs G Orman Preston Aberdeen Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> DUE TO (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>Arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial asthma</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 15</i> , 19 <i>56</i> , to <i>April 4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>April 4</i> , 19 <i>56</i> , and that death occurred at <i>7:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. J. Plunkitt, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>617 W. Belair Ave</i> DATE SIGNED <i>4-5-56</i>	
PHYSICIAN'S NAME (Type) <i>Aberdeen, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/7/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wesleyan Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen Rural Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarniey</i> ADDRESS <i>Aberdeen Md.</i>		24a. REC'D BY REGISTRAR <i>Apr 10-56</i>	24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>

11 1950

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04108

4099

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve-de-Bace</u>	c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forrest Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Roketa</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>49</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Howard Martine</u>		14. MOTHER'S MAIDEN NAME <u>Fester May Pyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>James Allen Smith</u> Address <u>Forrest Hill, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u> <u>4 M.S.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>prolapsed uteri</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>April 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>56</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>4/15/56</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD P HUDSON</u>		<u>FOREST HILL, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Center Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Forest Hill Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Baker Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-16-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie L. Lowndes</u>

BUREAU V. S.

APR

REG-35

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

4121

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Lusau</u> Middle <u>Stansbury</u> Last <u>Stansbury</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8th</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7th 1872</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Webster</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Olevia Stansbury Perryman, wid.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/23</u> 19 <u>53</u> , to <u>4/7</u> 19 <u>56</u> , that I last saw the deceased alive on <u>4/7</u> 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>568 Revolution St., Hagerstown, Md.</u> DATE SIGNED <u>4/9/56</u> ACTUAL SIGNATURE <u>George T. Stansbury</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union U. S. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Rural. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garrison</u> ADDRESS <u>Aberdeen Md.</u>				24a. REC'D BY REGISTRAR <u>Apr 11-56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Olevia Stansbury</u>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 W 100/200

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4122

## CERTIFICATE OF DEATH

04110

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUBLIN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUBLIN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>EDWARD</b> Last <b>SWIFT</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 12, 1881</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE CO.</b>		11. BIRTHPLACE (State or foreign country) <b>DUBLIN, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>MARILLA SWIFT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-3070</b>		17. INFORMANT Address <b>MRS. MARY J. SWIFT, DARLINGTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Cerebral End myocardial</b> <b>122.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>14R</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT</b> , 1955, to <b>APRIL</b> , 1956, that I last saw the deceased alive on <b>APRIL 23</b> , 1956, and that death occurred at <b>54</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Darlington Md</b> DATE SIGNED <b>4/25/56</b> ACTUAL SIGNATURE <b>Dudley Phillips Md</b> M.D. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-27-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DUBLIN SOUTHERN</b>		22d. LOCATION (City, town, or county) (State) <b>DUBLIN, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbins, Delta, Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>4-30-56</b>		24b. REGISTRAR'S SIGNATURE <b>Marilla Lowwood</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V 5

1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

041111

Reg. Dist. No.

187

4123

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 152</u>		d. STREET ADDRESS <u>Route 152</u>	
3. NAME OF DECEASED (Type or print) <u>Doris</u> First <u>Watson</u> Last		4. DATE OF DEATH <u>April</u> Month <u>25</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. E. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Nichols</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Oliver Watson</u>		Address <u>Route 152, Fallston, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY H. WITZKE</u> ADDRESS <u>4101 N. HANCOCK ST. BALTO. MD.</u>		24. READ BY REGISTRAR <u>April 25, 1956</u>	
25. REGISTRAR'S SIGNATURE <u>Paula Forward</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 30 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04112

4100

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> 83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 S. South Court</u>			d. STREET ADDRESS <u>6609 Glen Carlyle Drive</u>		
3. NAME OF DECEASED (Type or print) First <u>OEL</u> Middle <u>—</u> Last <u>WINGO</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>—</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21st 1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Jasper Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Myzatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>C. Clyde F. Wingo, Falls Church Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary artery thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>April 1, 1956</u> to <u>April 2, 1956</u> , that I last saw the deceased alive on <u>April 1, 1956</u> , and that death occurred at <u>2:20</u> A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave</u>		DATE SIGNED <u>April 2</u>	
PHYSICIAN'S NAME (Type) <u>Aberdeen Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>April 2-1956</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Springfield, Green Co Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarny Aberdeen Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>April 2-56</u>	24b. REGISTRAR'S SIGNATURE <u>Willie K. Henry</u>

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NEW YORK

BUREAU V. S.

APR 4 1956

RECEIVED